BEFORE THE BOARD OF PATENT APPEALS AND INTERFERENCES

Application No. 09/976,481
Filed: 12 October 2001
Applicant: BUTZ, Stephen
Art Unit: 2161
Examiner: Charles Edward Lu
Title: SOFTWARE SYSTEM FOR QUANTITATIVE MEASUREMENT AND ACCOUNTABILITY FOR SOCIAL SERVICES

APPELLANT'S REPLY BRIEF

Mail Stop Mail Stop Appeal
Brief-Patents
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sirs:

In response to the Examiner's Answer dated 19 October 2007, Appellant herewith submits its Reply Brief. Please charge the requisite fee under 37 C.F.R. 41.20(b)(2) of $255.00 and any missing or insufficient fees to our Deposit Account No. 50-3391. The Status of Claims and Grounds of Rejection To Be Reviewed On Appeal are as set forth in Appellant's Appeal Brief.

ARGUMENT

1st: The Examiner clearly erred in rejecting claims 1 and 4-8 as anticipated under 35 U.S.C. 102(e) and (a) by Douglas et al (U.S. Patent 6,039,688).

Douglass '688 discloses a software system devoted to automatically generating a program of patient health and wellness milestones and that tracks compliance of the patient. Present claim 1 is drawn to a method for the storage and querying of social services data in a knowledge base that provides "*quantitative accountability for social services provided by a case worker to a client*". In this regard Appellant's Appeal Brief drew two general distinctions: 1) the present system manages the delivery of social services (it is not a medical records database); and 2) the present system tracks *provider* effectiveness, not the client (or patient's) progress.

With regard to 1), the Examiner's Answer interprets the term "social services" in light of the specification (pp. 4-5) as including patient care management. Therefore, Douglas teaches "social services." In other words, the Examiner contends that because Appellant uses the literal word "patient" a few times in the specification[1], the word "patient" must equal the word "client." Armed with this logic the Examiner proceeds to ignore the full literal language of Appellant's claims, and specifically any distinction between "social services provided by a case worker to a client" versus a "patient *therapeutic* behavior modification program" as described by Douglas [column 2, lines 20 et seq.]. This is error. Douglas references a "case advisor" but defines it as "a doctor, nurse, and/or other trained medical professional experienced in case management protocols and practices." Applicant's system is clearly directed to evaluating the efforts of social

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workers[2] who are merely professional counselors, not licensed health care providers. Social workers help people function the best way they can in their environment, deal with their relationships, and solve personal and family problems. A bachelor's degree in social work (BSW) degree is the most common minimum requirement to qualify for a job as a social worker; however, majors in psychology, sociology, and related fields may qualify for some entry-level jobs, especially in small community agencies. This fundamental distinction propagates through all of Appellant's claims, and is obviously very important. Indeed, Appellant founded his company called *Social Solutions* Corporation which now sells its software at http://www.socialsolutions.com/ under the tagline "We help organizations improve services to those in need by relating their efforts to desired outcomes." None of this has any relation to patient *therapeutic* behavior modification programs or feedback for the physician as described by Douglas. Against this backdrop Appellants claim language should be strictly construed and the Examiner errs by according an overbroad construction that essentially ignores language such as "social services provided by a case worker to a client", "goal-oriented client outcomes" and "maintaining quantitative accountability for social services." Based both on industry-accorded meaning and Applicant's manifest intent, these limitations distinguish Douglas et al. and there is no anticipation under 35 U.S.C. 102(e) and (a).

With regard to 2), the Examiner maintains that Douglas is directed to providing "quantitative accountability for social services provided by a case worker to a client (e.g., fig. 1, #10, #14) via a navigable user interface (e.g., fig. 39-58). In one breath the Examiner notes that "*All of the functional limitations in the claims are evaluated and considered, just like any other limitation of the claim, for what it fairly conveys to a person of ordinary skill in the pertinent art*

[2] Applicant provided a definition of "social services" in its Appeal Brief that was at odds

in the context in which it is used. MPEP 2173.05(g)." In the next breath the Examiner states that "*the cited claim language does not fairly convey to one of ordinary skill in the art Appellant's specific interpretations of "tracking the physician's (sic) effectiveness" or "provider accountability", and therefore these specific limitations have not been read into the claims.*" Just the contrary, the cited claim language has plain meaning and is further supported in the specification. The specification [page 7, line 12] succinctly states that "The present invention is a method for the tracking and assessment of social services based on defining client barriers to success and then objectively tracking progress of the social worker based on the reduction and/or elimination of those barriers.' Indeed, claim 8 specifically requires "a report assessing effectiveness of said case worker's efforts toward reducing said defined client barriers over time." One skilled in the art would readily understand the foregoing as comprising an assessment of the provider of the social services and not the recipient. One of ordinary skill in the art would instantly know what Appellant means by "tracking the physician's effectiveness" or "provider accountability", and would readily distinguish it from monitoring patient progress toward a set of milestones. Appellant's specification defines enumerated client barriers to productivity [page 17, line 6 et seq,] thereby giving meaning to "defined client barriers to productivity" as in the claims. These *defined* barriers are clearly distinguished from "progress elements" (equal to the milestones employed by Douglas) which are a separate non-overlapping element of the present claims. Indeed, a concrete example of the "report indicating reduction of said client barriers over time" is given at [page 21, line 8 et seq.] by which an agency may seek a caseworker-centric "Barrier Reduction Report" which details caseworker success with clients to help them overcome the barriers they face. FIG. 12 is an example "Barrier Reduction Report" report which details

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progress for one or more caseworkers, thereby "ensur[ing] that the agency can provide caseworkers (or caseworkers can provide the agency) with quantitative accountability for social services based on objective reduction of barriers." Thus, the Examiner errs in stating that *the cited claim language does not fairly convey to one of ordinary skill in the art...."* He errs in not giving it any construction at all nor any patentable weight.

Ignoring Appellant's essential claim language, the Examiner proceeds to correlate Douglas to the present claim elements, and the result is a foregone conclusion based on loose semantics. For example, the Examiner states "*For example, as the case worker makes recommendations (e.g., col. 18, II. 5-35, 34-65), a report showing reduced client barriers (fig. 45) shows positive progress, which is an assessment of the case worker's efforts*. This simply is not true. A patient's positive progress may or may not be indicative of a provider's efforts. A provider's efforts entail time spent with a client, and steps taken during that time. Douglass does not measure these variables, and cannot correlate efforts to outcomes. This distinction is explained more fully at page 21, line 8 et seq., where the present system measures "caseworker effects in specific contact types over time. These contact types are mapped to outcome indicators (like promotions) and it becomes possible to assess how effective caseworkers are when their contact types (efforts) lead to desired outcomes. Thus, the present system "assess[es] how effective caseworkers are in reducing barriers over time. Douglass only assesses a patients positive progress toward milestones. Therefore, Douglas et al '688 fails to anticipate claim 1.

As to claim 4, The Examiner contends that Douglas teaches "*wherein the step of collecting information relating to defined client barriers to productivity further comprises selection of pre-defined itemized barriers to client productivity and for each itemized barrier a severity of said*

barrier (e.g., fig. 5, #51, fig. 45, scale from 1-4, note that these items and values have to be collected and selected first, before they can be stored/displayed see fig. 40, col. 18, II. 5-35). However, the cited FIG. 5 and accompanying description illustrate a form to be filled in by a physician or case advisor to assign intensity levels 51 to a patient's self-improvement regimen of diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements. This is exactly the opposite of "defined client barriers to productivity...and for each itemized barrier a severity of said barrier" as required by claim 4.

The difference becomes even more apparent when one considers that claim 4 requires *both* selection of predefined goal-oriented client outcomes; and selection of predefined client barriers to productivity and for each itemized barrier a severity of said barrier. Goal-oriented information is defined in the specification as "progress elements (points for improvement)". Exemplary Progress Elements may include Retention; New Employment; Wage Increase; Promotion; and Educational Advancement. Barriers to productivity are defined as social barriers faced by the client in accomplishing predefined social goals. In the context of employment placement, an exemplary set of predefined Barriers will include Day Care (whether the client requires day care for dependants); Transportation (whether the client requires transportation to/from work); Health Issues; Family Issues (e.g., divorce situation); Behavior (behavioral issues); Attitude; Weight; Personal Hygiene, Disability, Laziness; Money Management; Lack of Skills; and Literacy.

If we construe Douglass at fig. 5, #51, fig. 45, scale from 1-4 (diet, exercise, stress management, need for group support, anticipated compliance, and pharmaceutical requirements) as being barriers to success as the Examiner suggests, then the designation of forward-looking intensity (scale of 1-4 for purposes of implementing a health regimen) cannot be equated to a designation of current barrier severity as required by claim 4. Severity is severity not intensity.

As defined at page 17, line 6 of the specification "the corresponding severity is identified by a SeverityID field which may be a scale of from 1 (lowest severity) to 10 (most severe)." It requires a designation of severity to track a gradual reduction of severity as required by claim 4. Thus, the Examiner has misconstrued "for each itemized barrier a *severity* of said barrier" as encompassing Douglass' intensity designations.

As to claim 5, the Examiner contends that Douglas further teaches "a report assessing progress in reducing severity or eliminating said client barriers over time (met as shown by figs. 39-45). Fig. 40 shows a report tracking patient's progress in losing weight, exercising, etc. If as above we construe Douglass at fig. 5, #51, fig. 45, health regimen items as being "barriers" to success as the Examiner suggests, then figs. 39-45 merely indicate progress. Nowhere has there been any definition of barrier severity as required by claim 5, and nowhere does Douglas et al. report on any reduction *in barrier severity* as required by claim 5. Therefore, Douglas et al '688 fails to anticipate claim 5.

As to claim 8, this requires "at least one control for initiating a pre-determines query for allowing a user to generate a report assessing effectiveness of said case worker's efforts toward reducing said defined client barriers over time." Here again the Examiner equates Douglas' report showing positive progress (e.g., col. 18, II. 5-35, 34-65), with a report showing reduced client barriers (Fig. 45), and confuses Douglas' assessment of patient progress with "a report assessing effectiveness of said case workers efforts toward reducing said defined client barriers over time." as required by claim 8. Therefore, Douglas et al '688 fails to anticipate claim 8.

2nd: The Examiner clearly erred in rejecting claim 9 as obvious under 35 U.S.C. 103(a) over Douglas et al (U.S. Patent 6,039,688).

Claim 9 further defines the step of collecting information relating to defined goal-oriented client outcomes as being a predefined categorical list of progress elements including finding a new job, and educational advancement. The Examiner acknowledges that Douglass has no equivalent predefined progress elements yet contends that they are obvious since education and motivation is a two-pronged approach to behavior modification (Douglass col. 14, II. 10-24). The Examiner's logic here is entirely misplaced since it is irrelevant to the claim analysis whether motivational factors are part of behavior modification. The Examiner's logic provides no support for his proposition that one skilled in the art would include "educational advancement" in the list of progress elements Douglass et al. shows software for designing customized therapeutic behavior and lifestyle modification regimens and for tracking a patient's compliance with the regimen. Claim 9 succinctly requires specific information relating to progress elements including finding a new job or educational advancement, and Douglass does not teach or suggest any equivalent predefined progress elements. Claim 9 is not obvious.

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For the reasons set forth herein, it is believed that the Examiner erred and that this application clearly and patentably distinguishes over the prior art and the Examiner's primae facie rejections are traversed. Reversal is respectfully requested.

Respectfully submitted,

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